STATE OF CALIFORNIA-HEALTH AND WELFARE AGENCY CONFIDENTIAL DEPARTMENT OF SOCIAL SERVICES

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE

TO BE COMPLETED BY REPORTING PARTY. PLEASE PRINT OR TYPE. IF USING COMPUTER, PLEASE TAB TO EACH GRAY FIELD TO ENTER INFORMATION. SEE GENERAL INSTRUCTIONS ON REVERSE SIDE.

RECEIVING AGENCY USE ONLY

County APS/Ombudsman Case Number

SSN

Law Enforcement Case/File Number

A. VICTIM

NAME (LAST NAME FIRST):	AGE:	DATE OF BIRTH:	SEX: ☐ M ☐ F	RACE:	LANGUAGE (CHECK ONE) ☐ NON-VERBAL ☐ ENGLISH ☐ OTHER (Specify)
ADDRESS(IF FACILITY INCLUDE NAME):		CITY:			TELEPHONE ( )
PRESENT LOCATION (IF DIFFERENT FROM ABOVE)		CITY:			TELEPHONE ( )

☐DEVELOPMENTALLY DISABLED ☐MENTALLY DISABLED ☐PHYSICALLY HANDICAPPED ☐BRAIN IMPAIRED ☐FRAIL/ELDERLY (Functionally Impaired) ☐HOSPITALIZED ☐UNKNOWN ADULT

B. REPORTING PARTY

NAME (print)	Signature	Occupation	Date of this written report
Relation to Victim	Where to Contact: (street) (City)	(Zip Code)	Telephone ( )

C. INCIDENT INFORMATION

DATE/TIME OF INCIDENT(S)	PLACE OF INCIDENT (CHECK ONE) ☐OWN HOME ☐COMMUNITY CARE FACILITY ☐HOSPITAL ☐HOME OF ANOTHER ☐NURSING FACILITY ☐OTHER ADDRESS:	LEARNED OF INCIDENT BY (CHECK ONE) ☐VERBAL REPORT ☐OBSERVATION

D. REPORTED TYPES OF ABUSE (CHECK ALL THAT APPLY).

1. PERPETRATED BY OTHERS

a. PHYSICAL
☐ASSAULT/BATTERY
☐CONSTRAINT OR DEPRIVATION
☐SEXUAL
☐PHYSICAL AND/OR ☐ CHEMICAL RESTRAINT
☐MEDICATION
☐ISOLATION
(CHECK ALL THAT APPLY.)
☐OTHER SPECIFY)

b. ☐NEGLECT
c. ☐ABANDONMENT
d. ☐MENTAL SUFFERING
e. ☐FIDUCIARY
f. ☐OTHER (Specify)

2. SELF –INFLICTED

a. PHYSICAL
☐NEGLECT
☐SUBSTANCE ABUSE
☐OTHER PHYSICAL ABUSE

b. ☐SUICIDAL
C ☐FIDUCIARY
d. ☐ OTHER (Specify)

ABUSE RESULTED IN (CHECK ALL THAT APPLY)
☐ NO PHYSICAL INJURY ☐ MINOR MEDICAL CARE ☐ HOSPITALIZATION ☐CARE PROVIDER REQUIRED ☐ DEATH ☐ OTHER (SPECIFY) ____ ☐ UNKNOWN

E. Reporter's Observations, Beliefs, and Statements by Victim if Available. (List any Potential Danger for Investigator.)(Attach Additional Information)

F. COLLATERAL CONTACTS (INCLUDE PERSONS BELIEVED TO HAVE KNOWLEDGE OF VICTIM OR ABUSE, IF AVAILABLE)

NAME	ADDRESS	TELEPHONE NO.	RELATIONSHIP
		( )	
		( )	

G. FAMILY MEMBER OR OTHER PERSON RESPONSIBLE FOR VICTIM. (IF UNKNOWN, LIST CONTACT PERSON).

NAME:	IF CONTACT PERSON ONLY CHECK ☐	RELATIONSHIP
ADDRESS:		TELEPHONE ( )

H. RELATIONSHIP OF SUSPECTED ABUSER TO THE VICTIM

NAME OF SUSPECTED ABUSER ☐CARE CUSTODIAN (type) ☐HEALTH PRACTITIONER (type) ☐ PARENT ☐OFFSPRING ☐OTHER ☐SPOUSE ☐OTHER RELATION (specify)

ADDRESS	TELEPHONE ( )	SEX ☐M ☐F	RACE	AGE	D.O.B.	HEIGHT	WEIGHT	EYES	HAIR

I. VERBAL REPORT MADE (Check one ☐ Reported to Agency (See No. 1-5 on reverse side) ☐ Received by Agency (See No. 6 on reverse side).)

AGENCY:	OFFICIAL CONTACTED:	TELEPHONE: ( )	DATE:	TIME:

J. AGENCY USE ONLY

1. ☐Evaluatedlinvestigation not warranted By:
2. Assigned ☐ ER ☐Non-ER To:
3. Cross-Reported to: ☐ Ombudsman ☐ Law Enforcement ☐ CCL or Health Lic. ☐ Professional Board ☐ BMF & PA ☐ APS ☐ Other (Specify)

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